STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	14E701	A. Building B. Wing	05/14/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Big Meadows	1000 Longmoor Savanna, IL 61074

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0687 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate foot care. Based on observation, interview, and record review the facility failed to ensure footcare including monitoring and treatment was provided after a residents toe was cut during a podiatry visit for 1 of 3 residents (R37) reviewed for foot care in the sample of 31.The findings include:On 5/13/26 at 8:39 AM, R37 stated the doctor cut her toenail too short last time that she had her toenails trimmed. R37 stated there was bleeding to the big toe on the left foot after her toenails were cut. R37 stated she hasn't had her toenails cut since this happened.On 5/13/26 at 1:19 PM, V2 (Director of Nursing/DON) stated she was not aware of R37's toe being cut by the podiatrist and that it wasn't reported to her.On 5/14/26 at 8:30 AM, V2 (DON) stated she investigated R37 and the podiatrist cutting her toe. V2 stated she found a secure conversation written by the nurse to the resident's primary physician on 3/9/26 that showed R37 was seen by the podiatrist, her toenails were clipped, the left big toe was bleeding and wrapped by the podiatrist. The note stated the family wanted to use a Dremel or nail grinder for podiatry visits and asked if it was okay to use. The response from the doctor was to add her to his list. The doctor never said yes or no if it was okay to use the Dremel tool. V2 stated there weren't any treatment orders given for the cut on R37's toe. V2 stated the facility should have reviewed this closer. V2 stated they should have followed up on the secure conversation. V2 stated they should have followed up on what the doctor said and followed up on the visit with the doctor. V2 stated skin checks should have been done and a proper treatment put in place; R37 is diabetic. V2 stated they still don't have the podiatrist's notes from the visit. V2 stated an incident report should have been done after this; V2 stated she did one last night. A secure conversation note dated 3/9/26 for R37 showed she was seen by the podiatrist, her toenails were clipped, and the left toe was bleeding and wrapped by the podiatrist. The family was in to visit and wants to use a Dremel or nail grinder for all podiatry visits. The communication showed the nurse asked if this was okay and asked if the nurse practitioner could look at the resident's toe. The physician responded to add the resident to his list.R37's physician notes showed the doctor did not see her until 4/9/26. The physician's note showed he saw the resident that day for a routine nursing home visit. The note did not show anything regarding her toenails or the cut to her left big toe.The New Skin Alteration Incident that V2 filled out on 5/13/26 for R37 showed on 3/9/26 the podiatrist visited and performed toenail care to the left foot, nicked the resident's left foot and bleeding was noted. R37 witnessed the provider nicking her left great toe during the treatment.The Nurse's Note entered by V2 (DON) dated 5/14/26 for R37 showed her left great toe was assessed on 5/14/26 (two months after the incident) with no open areas noted around the toe. The toenail was noted with black and yellow discolorations under the nail bed of the left great toe. R37 denied pain to the area when it was palpated.The Face Sheet dated 5/14/26 for R37 showed diagnoses including type 2 diabetes mellitus, hypertension, gout, edema, muscle weakness, anemia, and obesity.The Care Plan for R37 dated 2/23/26 did not show any concerns related to foot/toenail care and her diabetes.The facility's Skin Integrity - Foot Care policy (2025) showed it is the policy of this facility to ensure residents receive proper treatment and care within professional standards of practice and state scope of practice, as applicable, to maintain mobility and good foot health. This policy pertains to maintaining the skin integrity of the foot. The facility will provide foot care and treatment in accordance with professional standards of practice (continued on next page)

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

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F 0687 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	including the prevention of complications from the resident's medical conditions. Medical conditions will be managed and interventions will be implemented in accordance with professional standards of practice to prevent complications of medical conditions. Registered nurses - RN and licensed practical nurses - LPN will participate in the management of medical conditions by following physician orders, assessment of residents, and reporting changes in condition to the resident's physicians. Interventions will be modified in a resident's plan of care as needed.

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. Based on observation, interview, and record review, the facility failed to ensure a gait belt was applied and used correctly during a transfer and failed to ensure a bed alarm was turned on for 2 of 2 residents (R37 & R4) reviewed for safety in the sample of 31.The findings include:1. On 5/12/26 at 12:56 PM, V11 (Certified Nursing Assistant/CNA) took a gait belt and put it loosely around R37's lower chest are slightly above her hanging breasts. V11 assisted R37 to transfer from the wheelchair to the toilet and the gait belt moved up under R37's arms. V11 stated that she tries to put the gait belt under R37's breast but sometimes places it on the resident's chest just under her armpits because it is more comfortable. V11 stated R37 transfers with supervision and did not need the gait belt. V11 stated a resident that is a one assist for transfers needs a gait belt.On 5/13/26 at 1:19 PM, V2 (Director of Nursing/DON) stated gait belts should be applied around a resident's waist. The gait belt should not be around the chest and under the residents' arms. That is not appropriate to be up there; the center of gravity would be off. V2 stated R37 was to have a gait belt for transfers for her safety.On 5/14/26 at 2:20 PM V4 (Licensed Practical Nurse/LPN) stated gait belts are applied around the resident at the waist to for support and resident safety.The Care Plan dated 3/6/26 for R37 showed she transfers with 1-2 staff into a wheelchair. R37 does not walk and chooses not to. R37 has a history of a left shoulder dislocation but does not wear a sling any longer.The facility's Use of Gait Belt policy (2025) showed it is the policy of the facility to use gait belts with residents that cannot independently ambulate or transfer for the purpose of safety. All employees will receive education on the proper use of gait belt during orientation and annually.2. On 5/13/26 at 9:25 AM, R4 was on his back in bed. R4 had a bed alarm on his bed that was not turned on. At 9:30 AM V7 (CNA) was called to the room and confirmed that the bed alarm was off and should be turned on. V7 turned the alarm on and stated that an agency nurse had this resident and was told that the alarm needed to be turned on. V7 stated R4's alarm needed to be on for his safety because he gets out of bed. V7 stated that is why the mattress is on the floor because he will fall to his knees.On 5/13/26 at 1:33 PM, V2 (DON) stated R4 should have the bed alarm on when he is in bed and that it is for fall prevention. V2 stated he has had that in place for a long time for his falls. The face Sheet dated 5/14/26 for R4 showed diagnoses including dementia, epilepsy, major depressive disorder, generalized anxiety disorder, hypertension, irritability and anger, history of falling, left artificial knee joint, tear of medial meniscus of right knee, right shoulder rotator cuff complete tear or rupture, osteoarthritis, and failure to thrive.The Care Plan dated 2/18/26 for R4 showed that R4 is at risk for falls related to a history of falls, diagnosis of seizures, and receives psychotropic medications to help manage moods. Sensor pad alarm in bed.The facility's Resident Alarms policy (2025) showed it is the policy of this facility to utilize resident alarms in limited circumstances, in accordance with the resident's needs, goals, and preferences, so the resident will be able to attain or maintain his or her highest practical level of physical, mental, and psychosocial well-being. The facility shall establish and utilize a systemic approach for safe and appropriate use of resident alarms.implement interventions to reduce risk; and monitor for effectiveness of the interventions and modifying interventions when necessary. When alarms are utilized, additional monitoring shall be provided, including but not limited to: verifying alarms are used in accordance with the resident's care plan. Verifying alarms are working properly.

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F 0804 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure food and drink is palatable, attractive, and at a safe and appetizing temperature. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review the facility failed to ensure that food was served at palatable temperatures. This applied to residents reviewed for dining/palatable food which included R33, R37, R66 and the resident council in the sample of 31.The findings include:On 5/12/26 at 10:13 AM, R33 stated she eats in her room and in the dining room. R33 stated her food is served cold all the time.On 5/12/26 at 10:21 AM, R66 stated he eats in his room and his food that is supposed to be warm is cold by the time it gets to him. R66 stated the staff just drop his food tray off and leave. R66 stated he had told staff about and he was not aware he could have staff warm up his food.On 5/13/26 at 8:39 AM, R37 stated that sometimes her hot food is served cold. R37 stated yesterday when she received her lunch tray her ice cream was melted. R37 stated she doesn't know why that is and that she guesses it is just the way it is.On 5/13/26 at 10:34 AM, during the resident council meeting the residents stated that the hot food is served cold sometimes and they don't like it. They stated they were not crazy about the food to begin with and don't like the food to be served cold. They stated the food that is supposed to be warm is served cold in the dining room and for room trays.R33's Minimum Data Set (MDS) dated [DATE] showed no cognitive impairment. R66's MDS dated [DATE] showed no cognitive impairment. The MDS dated [DATE] for R37 showed no cognitive impairment.The February 23, 2026 Resident Council Meeting Notes showed room trays were getting cold food. Residents request the use of insulated covers and to stop using foil. Residents believe the microwave is broken as it does not properly heat food. Food in the dining room is cooling down too fast before being served.The March 16, 2026 Resident Council minutes showed residents stated the room trays were being delivered without the thermal food cover containers.The April 20, 2026 Resident Food Council Minutes showed there were issues with room tray delivery. Residents stated trays are being delivered without the thermal food cover containers. There are delays and other issues with food.On 5/13/26 at 1:41 PM, V1 (Administrator) stated she is currently over the dietary department. V1 stated they have been getting cold food complaints. V1 stated the room trays are all being plated up at the same time and then taken out to the halls, but they cool off because they sit on the rack waiting to be served. V1 stated the hot food should be served hot. The facility's Menu and Adequate Nutrition policy (2026) showed the facility will provide residents with nourishing, palatable and well balanced diets that meet his or her daily nutritional and special dietary needs, taking into consideration the preferences of each resident and establish menus based upon this guidance.